MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore 18

CERTIFICATE OF DEATH

File 17075

Reg. Dist. No. 200

1. PLACE OF DEATH:

County: Kent

City or town: Colts Md.

(If outside city or town limits, write RURAL and give nearest town)

How long in above place of death? No of Years

Hospital, institution, or street address where death occurred:

How long in hospital or institution? None

2. USUAL RESIDENCE (HOME) OF DECEASED:

(For newborn infants give residence of mother)

State: Maryland County: Kent

City or town: Colts md

(If outside city or town limits, write RURAL and give nearest town)

Street No.

(If rural, give LOCATION)

2.(a) If veteran, name war: no

3.(a) FULL NAME: Florence H. Conner

3.(b) Social Security Number: ######

4. Sex	5. Color or race	6.(a) Single, married, widowed, or divorced
Fmale	White	Widow

6.(b) Name of husband or wife: John M. Conner Deceased

6.(c) If alive, give age ..... years

7. Birth date of deceased (mo., day, yr.): Feb. 7. 1873

8. AGE: Years	Months	Days	If less than one day
72	5	6	..... hrs. ..... min.

9. Birthplace: Delaware (Town, county, and state)

10. Usual occupation: House wife

11. Industry or business: Home

FATHER — 12. Name: Samuel Higgins

FATHER — 13. Birthplace: Delaware

MOTHER — 14. Maiden name: Alla Simmons

MOTHER — 15. Birthplace: Pa.

16. Informant: Mrs. Mrs F. A. Shunder

Address: Delaware City. Del.

17. Burial (Burial, cremation, or removal: Which?) Date thereof 7-15-45 (month) (day) (year)

Cemetery or crematory: Townsend cemetry (Townsend)

Location

18. Funeral director: G. Leslie Daniels

Address: Townsend Del

19. July 14 1945 (Date rec'd by Registrar) Mr. Brinton Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH: July 11. 1945 at 11 P M

21. I CERTIFY that death occurred on the date above stated; that I attended deceased from ..... 19..... to ..... 19..... and last saw ..... alive on ..... 19.....

Did not attend Investigated death and signed certifivater as Deputy Med. Exam. ent Co Md.

	DURATION
Immediate cause of death: Apoplexy	
Due to: Myocarditis	
Due to: Arterio Sclerosis	
Due to:	
Other conditions	

(Include pregnancy within 3 months of death)

Major findings of operation: None Date of op.

Autopsy results: None

PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:

Accident, suicide, or homicide: no Date of

Where did injury occur? (City or town) (County) (State)

Injured at home, farm, industry, public place (where?)

Means of injury: Injured at work?

23. SIGNATURE: Paul Grulls M.D.

Deputy Med. Exam. Kent Co Md.

Address: Chestertown Md Date signed: July 13.45

VS A15

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

MARGIN RESERVED FOR BINDING

~~Evidence for change of~~
~~... ...~~
~~FILE NO. G 9 [redacted] 1945~~

07076

VS A15

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

MARGIN RESERVED FOR BINDING

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore (167)

CERTIFICATE OF DEATH

Reg. Dist. No. 500

1. PLACE OF DEATH:
County: Kent
City or town: near Galena, Md
(If outside city or town limits, write RURAL and give nearest town)
How long in above place of death? all life
Hospital, institution, or street address where death occurred: —
How long in hospital or institution? —

2. USUAL RESIDENCE (HOME) OF DECEASED:
(For newborn infants give residence of mother)
State: Maryland County: Kent
City or town: Galena
(If outside city or town limits, write RURAL and give nearest town)
Street No.
(If rural, give LOCATION) —
2.(a) If veteran, name war

3.(a) FULL NAME: Mary Ann Butler

3.(b) Social Security Number: —

4. Sex: Female
5. Color or race: Colored
6.(a) Single, married, widowed, or divorced: Widow
6.(b) Name of husband or wife: Don't Know
6.(c) If alive, give age ... years
7. Birth date of deceased (mo., day, yr.): Don't Know [redacted]

8. AGE: Years 72 / 77 | Months | Days | If less than one day ... hrs. ... min.

9. Birthplace: Kent Co Md
(Town, county, and state)
10. Usual occupation: House work
11. Industry or business: Home
FATHER 12. Name: Frank Hackett
13. Birthplace: Kent Co Md
MOTHER 14. Maiden name: Martha Milligan
15. Birthplace: Kent Co Md
16. Informant: Evelyn Butler
Address: Galena Md

17. Burial (Burial, cremation, or removal. Which?) Date thereof: Aug. 1, 1945 (month) (day) (year)
Cemetery or crematory: John Wesley
Location: Davis Hill, Md.
18. Funeral director: Edward Fellows
Address: Millington, Md.
19. 7/30/45 (Date rec'd by registrar) 19 Elizabeth J. Mullen, Local Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH: July 28, 1945, at about 7:30 P. M.

21. I CERTIFY that death occurred on the date above stated; that I attended deceased from ... 19 ... to ... 19 ...; and that I last saw h... alive on ... 19 ...
Did not attend. Inquest. Signed certificate.
Immediate cause of death: Stopped well. Infant[?]
Hemorrhage ... — DURATION: Immediately[?]
Due to: Chest probable apparent stab wound.
Due to: multiple lacerations head & face
Other conditions
(Include pregnancy within 3 months of death)
Major findings of operations: None — Date of op.
Autopsy results: No
PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:
Accident, suicide, or homicide: Homicide — Date of: July 28/45
Where did injury occur: near Galena (City or town) (County) Md (State)
Injured at home, farm, industry, public place (where?)
Means of injury: Probably stab wound — Injured at work? No

23. SIGNATURE: Frank Hines M.D. Dep. Med. Examiner, Kent Co — M. D. or other
Address: Chestertown Md — Date signed: July 30/45

Evidence for change of age of deceased is shown on FILM No G 97 AUG 17 1945

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore (24)

CERTIFICATE OF DEATH

07077

★ Reg. Dist. No. 209

1. PLACE OF DEATH:

County Kent

City or town Chestertown

(If outside city or town limits, write RURAL and give nearest town)

How long in above place of death?

Hospital, institution, or street address where death occurred:

How long in hospital or institution?

2. USUAL RESIDENCE (HOME) OF DECEASED:

(For newborn infants give residence of mother)

State Maryland County, Kent.

City or town Chestertown

(If outside city or town limits, write RURAL and give nearest town)

Street No.

(If rural, give LOCATION)

2.(a) If veteran, name war

3.(a) FULL NAME Vivian A. Doman

3.(b) Social Security Number

4. Sex	5. Color or race	6.(a) Single, married, widowed, or divorced
Female	Colored	Married

6.(b) Name of husband or wife Wm. Doman

6.(c) If alive, give age ..... years

7. Birth date of deceased (mo., day, yr.) Oct. 14, 1900

8. AGE: Years	Months	Days	If less than one day
44	45		..... hrs. ..... min.

9. Birthplace Chestertown, Kent Co., Md.
(Town, county, and state)

10. Usual occupation Housewife

11. Industry or business

FATHER 12. Name Charles Buckey

13. Birthplace Md.

MOTHER 14. Maiden name Eleanor Eggleston

15. Birthplace Md.

16. Informant Viola Buckey

Address Chestertown, Md.

17. Burial (Burial, cremation, or removal. Which?) Date thereof Aug. 2, 1945 (month) (day) (year)

Cemetery or crematory Chestertown

Location Chestertown, Md.

18. Funeral director Edward Fellows

Address Millington, Md.

19. 7/31 1945 M. Brin Registrar
(Date rec'd by registrar)

MEDICAL CERTIFICATION

20. DATE OF DEATH July 29 1941, at 9 P. M.

21. I CERTIFY that death occurred on the date above stated; that I attended deceased from June 10 1941 to July 29 1941 and that I last saw her alive on July 22 1941

Immediate cause of death	DURATION
Mitral Stenosis	6 months
Cardiac Failure	2 days
Due to Auto accident	Instant.
Due to	
Other conditions	

(Include pregnancy within 3 months of death)

Major findings of operations

Date of op.

Autopsy results

PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:

Accident, suicide, or homicide Date of

Where did injury occur? (City or town) (County) (State)

Injured at home, farm, industry, public place (where?)

Means of injury Injured at work?

23. SIGNATURE Wm. Brin M. D. or other

Address Millington Date signed 7/31/1941

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

MARGIN RESERVED FOR BINDING

VS A15

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore

07078

CERTIFICATE OF DEATH ★

Reg. Dist. No. 202

1. PLACE OF DEATH:

County: Kent

City or town: Chestertown

(If outside city or town limits, write RURAL and give nearest town)

How long in above place of death? Lifetime

Hospital, Institution, or street address where death occurred:

Kent St.

How long in hospital or institution?

2. USUAL RESIDENCE (HOME) OF DECEASED:

(For newborn infants give residence of mother)

State: Md. County: Kent

City or town: Chestertown

(If outside city or town limits, write RURAL and give nearest town)

Street No.

(If rural, give LOCATION)

2.(a) If veteran, name war: No

3.(a) FULL NAME: Fannie L. Edwards

3.(b) Social Security Number: none

4. Sex	5. Color or race	6.(a) Single, married, widowed, or divorced
female	white	widowed

6.(b) Name of husband or wife: Wm. Edwards

6.(c) If alive, give address: Deceased

7. Birth date of deceased (mo., day, yr.): March 9, 1856

8. AGE: Years	Months	Days	If less than one day
89	4	0	...hrs. ...min.

9. Birthplace: Kent Co. Maryland (Town, county, and state)

10. Usual occupation: Housewife

11. Industry or business

FATHER — 12. Name: William Maslin

FATHER — 13. Birthplace: Maryland

MOTHER — 14. Maiden name: Anna R. Maslin

MOTHER — 15. Birthplace: Maryland

16. Informant: Mrs. Raymond Bowers

Address: Kent St. - Chestertown, Md.

17. Burial (Burial, cremation, or removal. Which?) Date thereof July 12, 1945 (month) (day) (year)

Cemetery or crematory: Chester Cem.

Location: Chestertown, Md.

18. Funeral director: J. Willis Wells

Address: Chestertown, Md.

19. July 9 1945 (Date rec'd by registrar) Clara B. Barnes Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH: July 9. 1945 19... at 4.20 P.M.

21. I CERTIFY that death occurred on the date above stated; that I attended deceased from July 5. 1945 19... July 9. 1945 19... and that I last saw her alive on July 9. 1945 19...

	DURATION
Immediate cause of death: Cerebral Hemorrhage	3 days
Apoplexy	
Due to: Myocadial Degenration	Many
Due to: Arterio Sclerosis	years
Other conditions	

(Include pregnancy within 3 months of death) None

Major findings of operations:

None Date of op.

Autopsy results:

PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:

Accident, suicide, or homicide: No Date of

Where did injury occur? (City or town) (County) (State)

Injured at home, farm, industry, public place (where?)

Means of injury Injured at work?

23. SIGNATURE: Frank Hurd M.D.

Chestertown Md M. D. July 9. 45

Address Date signed

MARGIN RESERVED FOR BINDING

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

VS A15

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore (168)

07079

CERTIFICATE OF DEATH

★ Reg. Diat. No. 202

1. PLACE OF DEATH:

County: Kent

City or town: Chestertown

(If outside city or town limits, write RURAL and give nearest town)

How long in above place of death?

Hospital, Institution, or street address where death occurred: Kent & Queen Anne's Hospital

How long in hospital or institution?

2. USUAL RESIDENCE (HOME) OF DECEASED:

(For newborn infants give residence of mother)

State: Md. County: Q. A.

City or town: Ingleside

(If outside city or town limits, write RURAL and give nearest town)

Street No.

(If rural, give LOCATION)

2.(a) If veteran, name war: No

3. (a) FULL NAME: James Henry Funbank

3. (b) Social Security Number

4. Sex	5. Color or race	6.(a) Single, married, widowed, or divorced
M	W	Married

6.(b) Name of husband or wife: Annie Funbank

6.(c) If alive, give age: 65 years

7. Birth date of deceased (mo., day, yr.): April 16 - 1860

8. AGE: Years	Months	Days	If less than one day
85	3		..... hrs. ..... min.

9. Birthplace: Q. A. Co. (Town, county, and state)

10. Usual occupation: Retired Farmer

11. Industry or business

FATHER 12. Name: Joseph Funbank

FATHER 13. Birthplace: Q. A. Co.

MOTHER 14. Maiden name: Elizabeth ?

MOTHER 15. Birthplace: Q. A. Co.

16. Informant: Edward Funbank

Address: Chestertown Md

17. Buried (Burial, cremation, or removal. Which?) Date thereof July 23-45 (month) (day) (year)

Cemetery or crematory: Church Hill

Location: Church Hill, Md

18. Funeral director: Edgar L. Lane

Address: Church Hill Md.

19. July 23 1945 (Date rec'd by registrar) Clara L. Barnes Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH: July 20 1945 at 11.25 PM

21. I CERTIFY that death occurred on the date above stated; that I attended deceased from ..... 19..... to ..... 19.....

and that I last saw h... alive on ... 19.....

Immediate cause of death	DURATION
Fracture Base of Skull	
Due to Blow on Head	5
Due to	
Other conditions	

(Include pregnancy within 3 months of death)

Major findings of operations

Date of op.

Autopsy results

PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:

Accident, suicide, or homicide: Accident Date of 7-17-45

Where did injury occur? Pier (City or town) Q. A. (County) Md. (State)

Injured at home, farm, industry, public place (where?) Home

Means of injury Blow Head Injured at work? No

23. SIGNATURE: Daniel J Burke M.D.

M. D. or other

Address: Ingleside Md Date signed 7/21/45

VS A15

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

MARGIN RESERVED FOR BINDING

M

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should carefully be supplied. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

MARGIN RESERVED FOR BINDING

VS A15

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore (93d)

CERTIFICATE OF DEATH

07080

Reg. Dist. No. 201

1. PLACE OF DEATH:
County: Kent
City or town: Worton Md Rural
(If outside city or town limits, write RURAL NEAR and give town)
Street address, hospital, or institution: ——
Stay in hospital or inst. (yrs., or mos., or days): 5 years
Stay in this community (yrs., or mos., or days): 63 years

2. USUAL RESIDENCE (HOME) OF DECEASED:
(For newborn infants give residence of mother)
State: Maryland County: Kent
City or town: Rural Worton Md Ward No.
(If outside city or town limits, write RURAL NEAR and give town)
Street No.: Colemans
(If rural give LOCATION)
2(a) IF VETERAN, NAME WAR: ——

3. (a) FULL NAME: Laurence Garrison
3. (b) Social Security Number:

4. Sex: Male
5. Color or race: Colored
6. (a) Single, married, widowed, or divorced: Widower
6 (b) Name of husband or wife: Adda Garrison
6 (c) If alive, give age ______ years
7. Birth date of deceased (mo., day, yr.): aug 7 1881
8. AGE: Years: 63 Months: Days: If less than one day ____ hrs. ____ min.
9. Birthplace: Worton Md Rural
(Town, county, and state)
10. Usual occupation: Farm work
11. Industry or business: Farms
FATHER 12. Name: John Garrison
13. Birthplace: Kent Co Md
MOTHER 14. Maiden name: Sarah Wright
15. Birthplace: Maryland
16. Informant: Ronnie Walley
Address: Worton Md Rural
17. Burial (Burial, cremation, or removal. Which?) Date thereof: July 8 1945 (month) (day) (year)
Cemetery or crematory: Colemans Worton Md
Location: Worton Md Rural
18. Funeral director: R K Fellows
Address: Still Pond Md
19. July 8 1945 (Date rec'd by registrar) J M Clark Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH: July 5 1945, at 2 M

21. I CERTIFY that death occurred on the date above stated; that I attended deceased from ______ 19__ to ______ 19__, and that I last saw ______ alive on ______ 19__.
Did not attend. Depty Health Officer signed Certificate

Immediate cause of death: Cerebral Hemorrhage — DURATION
Due to: Hypertension — 2 yrs
Due to: Arteriosclerosis
Other conditions:
(Include pregnancy within 3 months of death)
Major findings:
Of operations: None
Of autopsy:

PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:
Accident, suicide, or homicide: No Date of
Where did injury occur? None (City or town) (County) (State)
Injured at home, farm, industry, public place (where?)
Means of injury: Frank Hines M.D. Injured at work?

23. SIGNATURE: Dep. Health Officer Kent Co M. D. or other
Address: Chestertown Md Date signed: July 7/45

STATE OF MARYLAND—CERTIFICATE OF DEATH

17081

MARGIN RESERVED FOR BINDING

N. B.—WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD. Every item of information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

V. S. No. 1

1. PLACE OF DEATH

County Kent — Registration Dist. No. 202

Village or City Chestertown — No. R. F. D. No 3 — St., — Ward

(If death occurred in a hospital or institution, give its NAME instead of street and number)

Length of residanca in city or town whare death occurred 65 yrs. — mos. — ds. How long in U. S. if of foreign birth? — yrs. — mos. — ds.

2. FULL NAME Wesley Houston

(a) Residence: No. R. F. D. No. 3 St., Ward.

(Usual place of abode) If nonresident give city or town and State

PERSONAL AND STATISTICAL PARTICULARS

3. SEX	4. COLOR OR RACE	5. SINGLE, MARRIED, WIDOWED, OR DIVORCED (write the word)
M	Col	Widowed

5a. If married, widowad, or divorcad HUSBAND of (or) WIFE of

6. DATE OF BIRTH (month, day, and year)

7. AGE Years	Months	Days	If LESS than 1 day, — hrs. or — min.
65			

OCCUPATION

8. Trade, profession, or particular kind of work done, as SPINNER, SAWYER, BOOKKEEPER, atc. Farmer

9. Industry or business in which work was dona, as SILK MILL, SAW MILL, BANK, etc. Farm work

10. Date daceased last workad at this occupation (month end year) Feb. 1945 — 11. Total tima (years) spant in this occupation life

12. BIRTHPLACE (city or town) Chestertown. Md (State or country)

FATHER

13. NAME Jake Houston

14. BIRTHPLACE (city or town) Md (State or country)

MOTHER

15. MAIDEN NAME Unknown

16. BIRTHPLACE (city or town) Md. (State or country)

17. INFORMANT Laura Brown (Address) Chestertown, Md

18. BURIAL, CREMATION, OR REMOVAL Place Chestertown Cemetery, Data July 15, 1945

19. UNDERTAKER A. Vinson Kenny (Address) Chestertown Md

20. FILED July 13, 1945 Clara L. Barnes. Registrar.

MEDICAL CERTIFICATE OF DEATH

21. DATE OF DEATH July (Month) 12 (Day), 1945 (Year)

22. I HEREBY CERTIFY That I attanded daceased from Feb. 25 1945, to July 12, 1945

I last saw h[illegible] aliva on July 12, 1945; daath is said to hava occurrad on tha date stated abova, at — m.

The PRINCIPAL CAUSE OF DEATH and ralatad causes of importance ware as follows:

	Data of onset
Hypertension Cardilis	3 yr

Other Contributory Causes of importance:

Name of operation — Date of —

What tast confirmed diagnosis? — Was there an autopsy?

23. If daath was due to external causes (VIOLENCE) fill in also the following:

Accidant, suicide, or homicide? — Data of injury —, 19—

Where did injury occur? (Specify city or town, county and State)

Specify whether injury occurred in INDUSTRY, in HOME, or in PUBLIC PLACE.

Manner of injury

Natura of injury

24. Was disaase or injury in any way related to occupation of decaased? no

If so, spacify

(Signad) Dr. Wm. Richmond M. D.

(Address) Chestertown, Md

If more blanks are needed, address State Registrar, 2411 N. Charles Street, Baltimore, Requesting U. S. No. 1.

UNITED STATES STANDARD CERTIFICATE OF DEATH

Statement of occupation.—Precise statement of occupation is very important, so that the relative healthfulness of various pursuits can be known. Make some entry in this section for every person aged 10 years or over. If the deceased had retired from business, report the occupation prior to retirement. Children not gainfully employed may be returned as at school or at home. For a woman whose only occupation was that of home housework, write housewife in answer to Question 8 and own home in answer to Question 9. For a person engaged in domestic service for wages, however, designate the occupation by the appropriate terms, as **servant—private family, cook—hotel,** etc. For a person who had no occupation whatever write none.

To be complete, an occupation return must state:

8.—The trade, profession, or particular kind of work done.
9.—The industry or business in which the work was done.
10.—The month and year the deceased last worked at the occupation.
11.—The number of years the deceased followed the occupation.

In stating the occupation, avoid the use of such indefinite terms as "employee," "worker," "operative," etc. Find out the particular kind of work done and return that, as **spinner, weaver,** etc.

In stating the industry or business, avoid the use of such general terms as "store," "factory," "mill," etc. State the particular kind of store, factory, mill, etc., as **grocery store, soap factory, cotton mill,** etc.

Distinguish carefully the different kinds of engineers by stating the full descriptive titles, as **civil engineer, mechanical engineer, mining engineer, stationary engineer,** etc. Avoid the term "laborer" when a more precise statement of the occupation can be secured. Do not use the word "mechanic," but give the exact occupation, as **carpenter, painter, machinist,** etc. Distinguish carefully between **retail merchants** and **wholesale merchants.** A person who sells goods should be called a salesman and not a clerk.

Statement of cause of death.—Cause of death means the disease, injury, or complication which causes death, not the mode of dying, e. g., heart failure, asphyxia, asthenia, etc. As principal cause name the disease or injury causing death. As related causes, name earlier morbid conditions, if any, related to the principal cause and any important complication of the principal cause. Under other contributory causes of importance, name other important diseases or injuries. Examples:

Example I

The principal cause of death and related causes of importance were as follows:	Date of onset
Arteriosclerosis	*1915*
Chronic interstitial nephritis	*1921*
Cerebral hemorrhage	*July 5, 1927*
Other contributory causes of importance:	
Gallstones	*May 1, 1923*

Example II

The principal cause of death and related causes of importance were as follows:	Date of onset
Attack of epilepsy	*1 week ago*
Run over by street car	*1 week ago*
Peritonitis	*3 days ago*
Other contributory causes of importance:	
Gastroenteritis	*1 year*

ADDITIONAL SPACE FOR FURTHER STATEMENTS BY PHYSICIAN

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore (83-a)

CERTIFICATE OF DEATH

87082

Reg. Dist. No. 20-27-203

1. PLACE OF DEATH:

County: Kent

City or town: Rock Hall Md.

(If outside city or town limits, write RURAL and give nearest town)

How long in above place of death? about 2 hours

Hospital, Institution, or street address where death occurred:

How long in hospital or institution?

2. USUAL RESIDENCE (HOME) OF DECEASED:

(For newborn infants give residence of mother)

State: Maryland County: Cecil

City or town: Chesapeake City R.F.D.

(If outside city or town limits, write RURAL and give nearest town)

Street No.

(If rural, give LOCATION)

2.(a) If veteran, name war: No.

3. (a) FULL NAME: Hazilet B. Lake

3. (b) Social Security Number:

4. Sex	5. Color or race	6.(a) Single, married, widowed, or divorced
Male	White	Married

6.(b) Name of husband or wife: Helen Virginia Lake

6.(c) If alive, give age: 39 years

7. Birth date of deceased (mo., day, yr.): Mar. 27, 1908

8. AGE: Years	Months	Days	If less than one day
37	4	3	...hrs. ...min.

9. Birthplace: Chesapeake City Md.

(Town, county, and state)

10. Usual occupation: Government chauffr.

11. Industry or business: Gov. cars.

FATHER — 12. Name: Reuben B. Lake

13. Birthplace: Chesapeake City, Md.

MOTHER — 14. Maiden name: Fannie D. Lum

15. Birthplace: Chesapeake City

16. Informant: Helen Virginia Lake - Wife

Address: Chesapeake City

17. Burial (Burial, cremation, or removal. Which?) Date thereof: 8-2-45 (month) (day) (year)

Cemetery or crematory: Bethel Cemetery

Location: Chesapeake City, R.F.D.

18. Funeral director: H. St. Pippin

Address: Elkton, Md

19. July 31 1945 (Date rec'd by registrar) Edwood Burgess Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH: July 30 1945 at 6 P.M.

21. I CERTIFY that death occurred on the date above stated; that I attended deceased from July 30 1945 to July 30 1945; and that I last saw h[illegible] alive on July 30 1945. Immediate cause of death: Acute Dilatation of Heart. Heart Failure. DURATION

Due to: Apoplexy

Due to:

Other conditions:

(Include pregnancy within 3 months of death)

Major findings of operations: None

Date of op.:

Autopsy results: No

PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:

Accident, suicide, or homicide: No Date of:

Where did injury occur? None (City or town) (County) (State)

Injured at home, farm, industry, public place (where?)

Means of injury: Injured at work?

23. SIGNATURE: Frank Hurd M.D.

M. D. or other

Address: Elkton, Md. Date signed: July 31/45

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

MARGIN RESERVED FOR BINDING

VS A15

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore 18

CERTIFICATE OF DEATH

07083

Reg. Dist. No. 202

1. PLACE OF DEATH:
County: Kent
City or town: Chestertown
(If outside city or town limits, write RURAL and give nearest town)
How long in above place of death? Life
Hospital, institution, or street address where death occurred:
How long in hospital or institution?

2. USUAL RESIDENCE (HOME) OF DECEASED:
(For newborn infants, give residence of mother)
State: Maryland County: Kent
City or town: Chestertown
(If outside city or town limits, write RURAL and give nearest town)
Street No.
(If rural, give LOCATION)
2.(a) If veteran, name war:

3.(a) FULL NAME: Anna Mae Stradley

3.(b) Social Security Number:

4. Sex	5. Color or race	6.(a) Single, married, widowed, or divorced
F	W	Widowed

6.(b) Name of husband or wife: (Late) Thos. V. Stradley
6.(c) If alive, give age: years

7. Birth date of deceased (mo., day, yr.): May 6 1874

8. AGE: Years: 71 | Months: 2 | Days: 21 | If less than one day: hrs. min.

9. Birthplace: Galena, Kent Co. Maryland
(Town, county, and state)

10. Usual occupation: Housewife

11. Industry or business: Home

FATHER
12. Name: John Henry Garvin
13. Birthplace: Kent Co. Maryland

MOTHER
14. Maiden name: Susan Pennington
15. Birthplace: Kent Co. Maryland

16. Informant: Mrs. J. Allan Stradley (Son)
Address: Chestertown Maryland

17. Burial (Burial, cremation, or removal. Which?) Date thereof 7/30/45 (month) (day) (year)

Cemetery or crematory: Galena
Location: Galena - Kent Co. Maryland

16. Funeral director: Maggie V. Williams
Address: Chestertown, Maryland.

19. July 30, 1945 (Date rec'd by registrar) Clara S. Barnes, Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH: July 27 1945 at 6:10 P. M.

21. I CERTIFY that death occurred on the date above stated; that I attended deceased from 7-24- 1945, to 7-26 1945, and that I last saw him alive on 7-26- 1945.

Immediate cause of death	DURATION
General debility	
Due to acute myocardial weakness	
Due to	
Other conditions	

(Include pregnancy within 3 months of death)

Major findings of operations: Date of op.

Autopsy results:

PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:
Accident, suicide, or homicide: Date of
Where did injury occur? (City or town) (County) (State)
Injured at home, farm, industry, public place (where?)
Means of injury: Injured at work?

23. SIGNATURE: H P Chelone M.D. M. D. or other
Address: Chestertown Date signed 7-28

VS A15

PLEASE WRITE PLAINLY, WITH INDELIBLE INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

MARGIN RESERVED FOR BINDING

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore (61)

CERTIFICATE OF DEATH

★ Reg. Dist. No. 201

1:71:84

1. PLACE OF DEATH:

County: Kent

City or town: (Corp.) Millington Rur.

(If outside city or town limits, write RURAL and give nearest town)

How long in above place of death? 3 years.

Hospital, Institution, or street address where death occurred:

How long in hospital or institution? —

2. USUAL RESIDENCE (HOME) OF DECEASED:

(For newborn infants give residence of mother)

State: Md. County: Kent

City or town: (Corp.) Millington

(If outside city or town limits, write RURAL and give nearest town)

Street No.: Morgnec – Kent Co. Md.

(If rural, give LOCATION)

2.(a) If veteran, name war: —

3.(a) FULL NAME: Jennie W. Tate

3.(b) Social Security Number: —

4. Sex	5. Color or race	6.(a) Single, married, widowed, or divorced
Female	Colored	Widowed

6.(b) Name of husband or wife: Anna Tate

6.(c) If alive, give age: Deceased years

7. Birth date of deceased (mo., day, yr.): July 29 1880

8. AGE: Years 64 Months 11 Days 18 If less than one day ... hrs. ... min.

9. Birthplace: Near Chestertown Kent Co. Maryland (Town, county, and state)

10. Usual occupation: Housewife

11. Industry or business: Home

FATHER — 12. Name: Henry Wilson

FATHER — 13. Birthplace: Wytheville, Va.

MOTHER — 14. Maiden name: Martha Caulk

MOTHER — 15. Birthplace: Morgan Va.

16. Informant: Mrs. Henry Tate – (Son.)

Address: Chestertown R.D. Maryland

17. Burial (Burial, cremation, or removal. Which?) Date thereof 7/20/45 (month) (day) (year)

Cemetery or crematory: Morgnec

Location: Morgnec Kent Co. Maryland

18. Funeral director: Marvin V. Williams

Address: Chestertown, Maryland.

19. July 19 1945 (Date rec'd by registrar) J. H. Clark Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH: July 17 1945, at 4 P.M.

21. I CERTIFY that death occurred on the date above stated; that I attended deceased from July 16 1945, to July 17 1945 and that I last saw him alive on July 16 1945

Immediate cause of death	DURATION
Mitral Stenosis	2 yrs.
Due to: Chron. Interstitial Nephritis	5 yrs.
Due to: Arterio Sclerosis	5 yrs.
Other conditions: Diabetes	15 yrs.

(Include pregnancy within 3 months of death)

Major findings of operations: ... Date of op. ...

Autopsy results: ...

PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:

Accident, suicide, or homicide: ... Date of ...

Where did injury occur? ... (City or town) (County) (State)

Injured at home, farm, industry, public place (where?) ...

Means of injury ... Injured at work?

23. SIGNATURE: Merritt Price M. D. or other

Address: Millington Md. Date signed: July 17 1945

VS A15

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

MARGIN RESERVED FOR BINDING

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore

CERTIFICATE OF DEATH

1:71:85

Reg. Dist. No. 251 200

1. PLACE OF DEATH:
County: Kent
City or town: Millington
(If outside city or town limits, write RURAL and give nearest town)
How long in above place of death?
Hospital, institution, or street address where death occurred:
How long in hospital or institution?

2. USUAL RESIDENCE (HOME) OF DECEASED:
(For newborn infants give residence of mother)
State: Maryland County: Kent
City or town: Millington
(If outside city or town limits, write RURAL and give nearest town)
Street No.
(If rural, give LOCATION)
2.(a) If veteran, name war

3.(a) FULL NAME: Elizabeth Jones Wallace

3.(b) Social Security Number

4. Sex	5. Color or race	6.(a) Single, married, widowed, or divorced
Fem.	White	Married

B.(b) Name of husband or wife: Paul C. Wallace
6.(c) If alive, give age: 32 years

7. Birth date of deceased (mo., day, yr.): April 6 - 1914

8. AGE:

Years	Months	Days	If less than one day
31	3	9	...hrs. ...min.

9. Birthplace: Kent County Md.
(Town, county, and state)
10. Usual occupation: Housewife
11. Industry or business
FATHER 12. Name: Jonathan Jones
13. Birthplace: Kent Co. Md.
MOTHER 14. Maiden name: Maggie Felton
15. Birthplace: Phila., Pa.
16. Informant: Mrs. Charles Anthony
Address: Millington Md.
17. Burial (Burial, cremation, or removal. Which?) Date thereof: July 19 1945 (month) (day) (year)
Cemetery or crematory: Millington Md.
Location: Millington Md.
18. Funeral director: Edgar L. Lane
Address: Church Hill Md.
19. July 18 1945 (Date rec'd by registrar) M. Bue Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH: July 15 1945, at 7 P.M.
21. I CERTIFY that death occurred on the date above stated; that I attended deceased from April 12 1945 to July 15 1945
and that I last saw h... alive on July 15 1945

	DURATION
Immediate cause of death: Coronary Occlusion (Embolism)	Sudden
Due to: Mitral Stenosis	Several years
Due to: Rheumatic Endocarditis	10 years
Other conditions	

(Include pregnancy within 3 months of death)

Major findings of operations
Date of op.
Autopsy results
PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:
Accident, suicide, or homicide: Date of
Where did injury occur? (City or town) (County) (State)
Injured at home, farm, industry, public place (where?)
Means of injury: Injured at work?

23. SIGNATURE: M. Bue M. D. or other
Address: Millington Md. Date signed: July 18 1945

MARGIN RESERVED FOR BINDING

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

VS A15